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A 290	482.21(c)(3) QAPI IMPROVEMENT MEASUREMENTS The hospital must measure its success after implementing actions aimed at performance improvement. This STANDARD is not met as evidenced by: Based on review of facility policy and procedure, medical record review and staff interviews, the facility failed to measure for staff compliance with Close Observation policy. Findings include: Review of facility policy "Special Precautions" effective 10-01-2005 on 08-07-2007 revealed "Purpose: To provide mechanisms for monitoring and intervening with patients that need special or additional precautionary measures to ensure the safety of themselves and/or others" . Further review revealed "Close Observation (CO) - CO is the most restrictive level of observation. Designated staff members ...shall be responsible for keeping the patient within arms length at all times ..." Closed medical record review on 08-07-2007 for patient #2 revealed a 60 year old male admitted to facility #1 on 3-08-2007 for paranoid schizophrenia. Review revealed the patient was placed on CO 1:1 (one to one close observation) 3-17-2007 for aggresion toward other patients. Further review of progress notes on 3-27-2007 at 0635 revealed "Pt (patient) remain CO 1:1 for	A 290		10/8/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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safety precaution. Pt slept only 2 hrs (hours) during the night. Pt up walking the floor, unsteady on his feet..." Review of progress notes on 3-27-2007 at 0745 revealed "Pt complain of Lt (left) knee pain, assess pt, pt would not stand on both feet Yell when this nurse touch pt...". Review of progress notes on 3-27-2007 at 1130 by the physician revealed "Pt has Lt hip fracture..." Review revealed the patient was transferred to facility #2 for surgical repair of the fractured hip and was readmitted to facility #1 on 4-01-2007. Review of progress notes on 4-15-2007 at 1145 by nursing staff revealed "Staff was sitting CO 1:1 (one to one close observation) (with) client in client ' s bedroom #208 while client was sitting in Geri chair. Client requested cup of water to drink, staff left client unsupervised for ' less than two minutes 'to go into nurses' station and get the water ...was found by staff lying on bedroom floor on back." Further review of progress notes on 4-27-2007 at 1340 by the social worker revealed "Call was placed to (spouse) to report the investigation of an incident where (the patient) was left alone while on 1:1 ..." The patient was discharged from the facility #1 on 6-19-2007.

Interview with a social worker on 8-07-2007 at 1555 revealed the progress note entered on 4-27-2007 1340 regarding the client being left alone while on 1:1 was while the client was ordered for CO. Interview revealed the incident occurred on 4-27-2007 while the patient was in the therapeutic mall. Interview revealed nursing supervisor staff observed the employee assigned to monitor the patient was not within arms length or visual sight of the patient.

Interview with nursing administrative staff on

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A 290	Continued From page 2 8-08-2007 at 1015 revealed the documented incidents of patient #2 being left unattended while on CO, 4-15-2007 at 1145 and 4-27-2007 at 1340, were investigated by the nurse manager and patient advocate. Interview revealed the facility's investigation determined the involved staff did not follow facility "Special Precautions" policy for CO. Interview revealed the facility had a history of an increase in patient incidents in the prior months related to being left unattended while on CO. Further interview revealed the investigation determined opportunities for improvement in policy clarification and staff education. Further interview revealed staff education and oversight for monitoring compliance was delegated to the nursing supervisor staff in the past month. Interview revealed administrative staff were unable to provide documentation of monitoring of staff compliance with CO 1:1. Interview with nursing supervisor staff on 8-08-2007 at 1330 failed to reveal knowledge of monitoring for staff compliance with CO 1:1. Interview failed to provide documentation of monitoring staff compliance with CO 1:1.	A 290		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical record reviews, and staff	A 395		10/17/07

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interviews, the facility failed to:

1. notify a physician of an acute change in a patient ' s condition for 1 of 5 records reviewed (#2);

2. monitor a patient for falls while on constant observation (CO) for 1 of 5 records reviewed (#2); and,

3. complete a falls risk assessment for 2 of 5 records reviewed (#2, #3).

Findings include:

1. notify a physician of an acute change in a patient ' s condition for 1 of 5 records reviewed (#2)

Review of facility policy "Incident/Accident Reports" effective 11-01-2003 on 8-08-2007 revealed "Unknown Injuries - Any physical evidence of injury or verbal complaint of injury where source or contributing cause in unknown" . Further review revealed "Staff members identifying an incident/accident shall ...alert the appropriate health care professionals immediately."

Review of progress notes by nursing staff on 3-27-2007 at 0745 revealed "Pt complain of Lt (left) knee pain, assess pt, pt would not stand on both feet Yell when this nurse touch pt...". Review of progress notes on 3-27-2007 at 1130 by the physician revealed "Pt has Lt hip fracture..."

Closed medical record review on 08-07-2007 for patient #2 revealed a 60 year old male admitted

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A 395	Continued From page 4	A 395		

to facility #1 on 3-08-2007 for paranoid schizophrenia. Review revealed the patient was placed on CO 1:1 (one to one constant observation) 3-17-2007 for aggresion toward other patients. Further review of progress notes dated 3-27-2007 at 0635 revealed "Pt (patient) remain CO 1:1 for safety precaution. Pt slept only 2 hrs (hours) during the night. Pt up walking the floor, unsteady on his feet..." Further review of progress notes by nursing staff dated 3-27-2007 at 0745 (one hour and 10 minutes later) revealed "Pt complain of Lt (left) knee pain. Assess pt. Pt would not stand on both feet, yell when this nurse touch pt...Pt would not put any wait down on Lt leg ...Pt yelling, very hyperactive. Placed on sick call. " Further review of progress notes by the physician ' s assistant dated 3-27-2007 at 0900 revealed "...Assessment - r/o (rule out) fracture, plan x-ray hip ...Increase Motrin to 800mg po(by mouth) q 8h (every eight hours). " Review of progress notes by the physician dated 3-27-2007 at 1130 revealed "Pt (patient) has (left) hip fracture..." Review of progress notes on 3-27-2007 at 1200 revealed "Was reported by 11(pm) - 7(am) nursing giving report this am (morning) that pt c/o (complained of) Lt knee pain ...When coming on unit this nurse assess pt at 745 am." Further review of progress notes dated 3-27-2007 at 1227 revealed "Pt transferred to (facility #2) ER (emergency room) via ambulance."

Interview with the unit Nurse Manager on 8-07-2007 at 1430 revealed the Manager completed an investigation of the incident. Interview revealed the patient ' s first report of the left knee pain was around 0650, just before the morning change of shift report to the on-coming Registered Nurse (RN). Interview revealed the

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off-going nurse reported the patient's complaint of pain to the on-coming nurse during shift report. Interview failed to reveal the off-going RN documented the patient's report of left knee pain in the medical record. Interview furthermore failed to reveal the off-going nurse reported the change in patient's condition to the physician. Interview revealed the on-coming RN assessed the patient at 0745 (approximately 55 minutes after the initial report of pain) and found the patient could not bear weight on the left leg and would yell when touched by the nurse. Interview confirmed the nurse placed the patient's name on the sick call. Interview revealed the "sick call" is a log for the physician assistant to reference for any patient care issues to consider during routine rounds. Interview failed to reveal the RN immediately notified the physician of the change in patient's condition.

Interview with a nursing supervisor on 8-08-2007 at 1330 revealed a patient report of increased pain, acute change in ability to ambulate, and inability to bear weight would be considered an acute change in a patient ' s condition. Further interview revealed the physician should be notified immediately with an acute change in a patient's condition.

2. ensure constant observation (CO) monitoring for a high risk falls patient for 1 of 5 records reviewed (#2)

Review of facility policy "Special Precautions" effective 10-01-2005 on 08-07-2007 revealed "Purpose: To provide mechanisms for monitoring and intervening with patients that need special or additional precautionary measures to ensure the safety of themselves and/or others" . Further

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review revealed "Close Observation (CO) - CO is the most restrictive level of observation. Designated staff members ...shall be responsible for keeping the patient within arms length at all times..."

Closed medical record review on 08-07-2007 for patient #2 revealed a 60 year old male admitted to facility #1 on 3-08-2007 for paranoid schizophrenia. Review revealed the patient was found to have a fracture of the left hip on 3-27-2007 while on CO monitoring. Review revealed the patient was transferred to facility #2 for surgical repair of the fractured hip and was readmitted to facility #1 on 4-01-2007. Review of progress notes on 4-15-2007 at 1145 by nursing staff revealed "Staff was sitting CO 1:1 (one to one close observation) (with) client in client's bedroom #208 while client was sitting in Geri chair. Client requested cup of water to drink, staff left client unsupervised for 'less than two minutes' to go into nurses' station and get the water ...was found by staff lying on bedroom floor on back.". Further review of progress notes on 4-27-2007 at 1340 by the social worker revealed "Call was placed to (spouse) to report the investigation of an incident where (the patient) was left alone while on 1:1..." The patient was discharged from the facility #1 on 6-19-2007.

Interview with a social worker on 8-07-2007 at 1555 revealed the progress note entered on 4-27-2007 at 1340 regarding the client being left alone while on 1:1 was while the client was ordered for CO monitoring. Interview revealed the incident occurred on 4-27-2007 while the patient was in the therapeutic mall. Interview revealed nursing supervisor staff observed the employee assigned to monitor the patient was not

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A 395	Continued From page 7 within arms length or visual sight of the patient. Interview with nursing administrative staff on 8-08-2007 at 1015 revealed the documented incidents of patient #2 being left unattended while on CO monitoring, 4-15-2007 at 1145 and 4-27-2007 at 1340, were investigated by the nurse manager and patient advocate. Interview revealed the investigation determined the involved staff did not follow facility "Special Precautions" policy for CO. 3. complete a falls risk assessment for 2 of 5 records reviewed (#2, #3) Review of policy "Falls Precautions" effective 11-27-2006 on 8-08-2007 revealed "Nursing Responsibilities - Registered Nurses are responsible for assessing fall risk upon admission ...using the Hendrich Fall Risk Assessment Tool." A. Closed medical record review on 08-07-2007 for patient #2 revealed a 60 year old male admitted to the facility on 3-08-2007 for paranoid schizophrenia. Review of document "Nursing Fall Risk Assessment" completed by a Registered Nurse (RN) on 3-08-2007 at 0540 revealed "Medication - Is the patient taking any of the following medications/categories ...Drugs that increase GI (gastro-intestinal) motility" checked "no" and "Drugs that alter thought process and/or create hypotensive effect (i.e. narcotics, anti-hypertensives, anti-convulsants ...) " checked "no" . Further review of the "Nursing Fall Risk Assessment" revealed "Patients that are on the above medications may be indicated for fall precautions" . Review of the "Nursing Fall Risk Assessment" revealed "Are Fall Precautions indicated?" checked "no" . Review	A 395		

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A 395	Continued From page 8 of admission orders dated 3-07-2007 at 0845 revealed an order for Norvasc (anti-hypertensive) 5mg(milligrams) po(by mouth) qam (every morning), Dilantin (anti-convulsant) 150mg qhs (at bedtime), and Lactulose (increases GI motility) 30ml (milliliters) po qhs (at bedtime). Interview with nurse management staff on 8-07-2007 at 1430 revealed the "Hendrich Fall Risk Assessment" is completed on the "Nursing Fall Risk Assessment tool" . Interview confirmed the RN completing the falls risk assessment failed to consider the medications ordered for the patient on the admission orders. Interview confirmed that considering the patient's admission medications the patient would have been considered a falls risk and falls precautions initiated. Interview confirmed nursing staff did not follow facility policy on completion of the Falls Risk Assessment Tool. Interview failed to reveal documentation the patient was placed on falls precautions on admission to the facility. B. Closed medical record review for patient #3 revealed a 57 year old male admitted to the facility 3-09-2007 for Paranoid Schizophrenia. Review of the record revealed a "Nursing Fall Risk Assessment Tool" which was not completed. Interview with nurse management staff on 8-07-2007 at 1430 revealed the "Hendrich Fall Risk Assessment" is completed on the "Nursing Fall Risk Assessment Tool" . Interview confirmed the admitting RN failed to complete the "Nursing Fall Risk Assessment Tool" . Interview confirmed the admitting RN failed to follow facility policy on completion of the Hendrich Fall Risk Assessment. Interview failed to reveal additional documentation	A 395		

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A 395	Continued From page 9 of the Hendrich Falls Risk Assessment.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical record reviews, and staff interview, the facility's nursing staff failed to incorporate falls risk into the patient treatment plan for 1 of 5 records reviewed (#4). Review of facility policy "Falls Precautions" effective 11-27-2007 on 8-08-2007 revealed "Interdisciplinary Treatment Team Responsibilities ...interventions to prevent falls shall be documented on the treatment plan." Open medical record review for patient #4 revealed a 67 year old female admitted to the facility on 8-06-2007 for Schizo-effective Disorder. Review of document "Nursing Fall Risk Assessment" dated 8-07-2007 at 0825 and completed by a Registered Nurse (RN) revealed "Are Fall Precautions indicated?" checked "yes" . Review of the Nursing Assessment dated 8-07-2007 revealed "Risk Assessment - Fall Risk - 'Fall Precaution'" . Further review of the Fall Risk section of the Nursing Assessment revealed "Consider for NCP (Nursing Care Plan)" to be left blank. Interview with administrative staff on 8-08-2007 at	A 396		10/17/07

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A 396	Continued From page 10 1300 revealed patients on falls precautions should have interventions documented on the treatment plan. Interview confirmed the admitting RN failed to document falls precaution interventions in the treatment plan. Interview confirmed the admitting RN did not follow facility policy in documenting falls precaution interventions on the treatment plan. Interview failed to reveal further documentation of falls precautions being incorporated into the patient ' s treatment plan.	A 396		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of medication and patient nourishment refrigerator temperature logs and staff interviews, the facility failed to: 1. ensure that medication supplies were maintained according to facility policy for 1 of 2 medication refrigerators observed. 2. ensure that patient nourishment supplies were maintained according to facility policy for 2 of 3 patient nourishment refrigerators observed.	A 724		10/17/07

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A 724	Continued From page 11 3. ensure supplies utilized for patient therapies were labeled and maintained per manufacturer ' s recommendations. Findings include: 1. ensure that medication supplies were maintained according to facility policy for 1 of 2 medication refrigerators observed. Observations during tour of the U2 adult psychiatric unit medication room on 8-08-2007 at 1215 revealed the medication refrigerator temperature log for dates 8-05-2007 and 8-06-2007 were left blank (two of seven days prior to day of tour for the "August" refrigerator temperature log not checked). Further observations during tour revealed staff food items being stored in the medication refrigerator. Interview with administrative staff during tour confirmed the facility policy for medication refrigerator checks is to log the temperatures daily. Interview confirmed staff did not follow facility policy on logging daily medication refrigerator checks. Interview further confirmed the facility policy is staff food items are not to be stored in medication refrigerators. Interview confirmed staff did not follow facility policy on no staff food items are to be stored in medication refrigerators. 2. ensure that patient nourishment supplies were maintained according to facility policy for 2 of 3 patient nourishment refrigerators observed. Observations during tour of the U2 adult psychiatric unit 3 West on 8-08-2007 at 1145 revealed the patient nourishment refrigerator	A 724		

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A 724	Continued From page 12	A 724		

temperature log for dates 8-04-2007 and 8-05-2007 were left blank. Observation of the refrigerator temperature log revealed patient nourishment temperature should be maintained at 33-40 degrees Fahrenheit. Further observations during tour revealed staff food items being stored in the patient nourishment refrigerator.

Interview with administrative staff during tour confirmed the facility policy for patient nourishment refrigerator checks is to log the temperatures daily. Interview confirmed staff did not follow facility policy on logging daily patient nourishment refrigerator checks. Interview further confirmed the facility policy is staff food items are not to be stored in patient nourishment refrigerators. Interview confirmed staff did not follow facility policy on no staff food items are to be stored in patient nourishment refrigerators.

Observations during tour of the U2 adult psychiatric unit 3 East on 8-08-2007 at 1220 revealed the patient nourishment refrigerator temperature log for dates 8-04-2007, 8-05-2007, 8-06-2007, and 8-07-2007 were left blank (four of seven days prior to day of tour for the "August" refrigerator temperature log not checked). Further observations during tour revealed the nourishment refrigerator temperature at the time of observation was at 53 degrees Fahrenheit. Observation of the refrigerator temperature log revealed patient nourishment temperature should be maintained at 33-40 degrees Fahrenheit. Further observations during tour of the U2 adult psychiatric unit 3 East on 8-08-2007 at 1220 revealed staff food items being stored in the patient nourishment refrigerator.

Interview with administrative staff during tour

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confirmed the facility policy for temperature ranges for nourishment refrigerators checks is 33 - 40 degrees Fahrenheit. Interview further confirmed facility policy is to notify maintenance of temperatures out of range. Interview revealed the current nourishment refrigerator temperature was out of range per facility policy. Interview revealed the nourishment refrigerator was in use for storage of patient nourishment items at time of observation. Interview further confirmed a work order had not been submitted for repair of the refrigerator. Interview confirmed staff did not follow facility policy on notifying maintenance for an out of range refrigerator temperature. Interview further confirmed the facility policy is staff food items are not to be stored in patient nourishment refrigerators. Interview confirmed staff did not follow facility policy on no staff food items are to be stored in patient nourishment refrigerators.

3. ensure supplies utilized for patient therapies were labeled and maintained per manufacturer ' s recommendations.

Observations during tour of the U2 adult psychiatric unit treatment room on 8-08-2007 at 1205 revealed the following items being stored on a counter top in the treatment room: a clear fluid being stored in an open medicine cup and unlabeled, a dark brown fluid being stored in an open medicine cup and unlabeled, a clear gel being stored in an open medicine cup and unlabeled, and a clear fluid being stored in an unlabeled approximately 16 ounce clear plastic bottle. Further observations during tour revealed an opened container of 0.9% Normal Saline solution for irrigation. Observation of the container label revealed " discard after single use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 724	Continued From page 14 " . Observations during tour revealed no patient was receiving treatment at the time of tour. Interview with administrative staff during tour revealed items on top of the counter top are utilized for patient treatments. Interview confirmed facility policy is for all containers to be labeled with contents or discard items after use with a single patient treatment. Interview confirmed staff did not follow facility policy on labeling of containers or discarding items after single patient treatment. Interview further revealed the container of 0.9% normal saline solution for irrigation was opened and should have been discarded after use. Observation during tour of the U2 adult psychiatric unit medication room on 8-08-2007 at 1215 revealed an opened container of 0.9% Normal Saline solution for irrigation being stored on a shelf above the medication preparation area. Observation of the container label revealed " discard after single use " . Observation revealed the irrigation solution was not in use at the time of tour. Interview with administrative staff during tour revealed the container of 0.9% normal saline solution for irrigation was opened and should have been discarded after use. NC00038458	A 724		